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ANSWERS TO BUREAU OF THE BUDGET JANUARY 19, 1965
QUESTIONS FOR H.E.W. REGARDING PROPOSED BILL
AUTHORIZING REGIONAL MEDICAL COMPLEXES

Purpose

1. What would enactment of this bill accomplish which does not occur at the present time? What are the new elements of organization, treatment, research, or training? How would they relate to existing programs?

At the present time, no adequate organizational mechanism exists whereby the highest quality medical care available in university medical centers can be brought to bear widely in a community. Community hospitals are eager for assistance from medical schools, but this usually cannot be provided by existing arrangements. Community-wide planning, whereby expensive duplication of services and equipment is avoided, is rudimentary at best. The provisions of the bill would bring about:

(a) Stimulation of appropriate health planning among medical centers, community hospitals, and other health agencies.

(b) Organizational frameworks whereby medical schools would provide services and personnel not otherwise available in community hospitals.

(c) Diagnosis and treatment, now obtainable at only a few locations, in more places and supervised by adequately trained doctors not otherwise available to the community hospitals.

(d) An improved selection of research patients, who could be selected from the total number in the community rather than from the smaller group now available through a university hospital.

(e) Training more extensive and varied than that now provided, since both a larger number of patients and a more varied set of circumstances would be available to the trainee.

2. Is the primary purpose of this bill to improve and expand treatment, or research? If a combination of the two, what is the proportion of each? Would this proportion apply to most complexes?

The primary purpose of the bill is to make better care more widely available. To do this requires that training, research and patient care be carried out concurrently. The proportion of each varies from time to time and from location to location. Medical schools would be asked to assume increased responsibility for community health care. At the same time, community hospitals would be asked to provide more resources for training and for research than they now do. Within flexible limits, the proportions of training, research and care would be similar in all complexes. Ideally, the proportions of the three, each to the others, would be about that now found in any top-quality university teaching service.

3. What is the relative priority which the Department places on the various elements of a Complex including:

a. central planning and administrative machinery for the complexes

b. medical centers

c. categorical research centers

d. community hospital diagnostic and treatment stations

e. other elements (please specify)

What effect would the omission of each of these respective elements have on the operation of this program?

The purpose of the bill is to bring about, by coordination of existing and to be created components, an organization of high-quality health activities on a larger scale than formerly has been possible. To do so requires medical centers, categorical research centers, and community hospital diagnostic and treatment stations all to participate in a

planned, centrally administered system. Each is necessary; to omit any would destroy the concept, and operation of the program would fail since it envisions coordinated and balanced performance of the parts.

Approach

1. Accepting the need to decrease the lag between new knowledge and its translation into medical practice, what are the specific advantages of taking action on a heart, cancer or stroke basis, as opposed to general support for research, training and demonstration applicable to all major diseases? What are the disadvantages of a categorical approach?

Medicine's spectacular advances in the past twenty years have occurred pari passu with the development of specialization. Regardless of what might have been, the fact is that 80 per cent of current medical graduates are undertaking specialty training. Specialists and only specialists can provide the high-quality of training, research and patient care which it is hoped to provide more widely in the community. Hence, for specialists in cardiovascular disease, categorical facilities are necessary, and so for other diseases as well.

2. What major diseases other than heart disease, cancer and stroke does the Department plan to include? On what basis would the Surgeon General and the Medical Complex Advisory Council select other diseases as proposed in the bill?

University affiliated mental health and mental retardation centers, now being developed under the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, fit easily into the organizational and planning aspects of the medical complexes. So do various other programs, such as the program-project grants in neurological and sensory diseases, and others. When, in the judgment of experts in a field, it is determined that advances are being made more rapidly than they are being applied, as is the case for heart disease, cancer and stroke, attacks upon these new diseases could well be launched through the organizational structure of medical complexes. In institutions having unique activities relating to other major diseases, the Surgeon General could designate other categories for specific support. To do so, under regulations, evidence that a major national service would be served would be

3. What effect will the proposed categorical approach have on the curricula of medical schools and on undergraduate medical education?

The complexes will have relatively little effect upon undergraduate medical education. Greater availability of excellent teaching cases, the increased volume of research and the greater rigor of diagnostic and therapeutic methods all will improve medical education, but only secondarily. The great educational impact of the complexes will be on graduate specialty training and upon the continuing education of community physicians.

Cost & Financing

1. What will the grant monies be used for, e.g.; Professional staff, ancillary staff, equipment, renovation, new construction, patient care? In what proportion? Who will decide?

Grant funds will be used for professional staff, ancillary staff, equipment, renovation, construction and patient care, but the latter only for care allocable to training, research or demonstration. The proportions would be as set forth in proposed budgets by the applicant institution. Such budgets would be reviewed, both by medical scientists and by administrative specialists, and would be subject to regulations similar to those promulgated for the clinical research units now operated through the N.I.H.

2. Assuming a complex to be established in the Washington, D. C. area, please indicate for what purpose, and in what relative amounts, the allocation of dollars will be made? Please be specific.

This question cannot be answered in the absence of a specific application.

Assume that George Washington University wished to make an application. Its representatives would arrange to form a local advisory group, as specified in the bill. This group, and the university representatives, would discuss with the governing boards of Georgetown and Howard Universities, and also with the proper authorities in the various community hospitals, the nature of agreements to be made whereby and under what conditions each independent institution would

join forces with George Washington be become a component of the complex. There would also be discussion with the Metropolitan Hospital Planning Council and any other official planning agency to determine the degree to which the complex would meet community needs. When all this had been done, the advisory group would assist George Washington University in preparing a provisional budget in which would be set forth the sums requested for use in each institution and in each budget category. This application would then be submitted to the Public Health Service. Staff review, analysis and negotiation with the applicant would follow, after which an amended proposal would be submitted to the Medical Complexes Advisory Council for review and to the Surgeon General for approval for payment. In this hypothetical instance, funds would be administered through George Washington University for the entire complex. In other instances, more than one complex might be located in a single city, or separate grants to fund specific parts of the same complex might be made to two or more different but cooperating institutions.

3. Why should the research function of the complex, including construction of research facilities, be financed other than through existing N.I.H. authorities and dollars?

Multiplicity of financing is inefficient and unnecessarily duplicative. Moreover, the N.I.H. authorizations permit only parts, not all, of the spectrum of activities to be assumed by the complex. Research grants, for example, cannot be used to pay salaries for teaching, yet the combination of teaching, research and patient care is essential to the proper functioning of the complex.

4. What is the relationship of complexes to existing and proposed Federal programs supporting medical education and the construction of medical schools?

The complexes have relatively little relation to current and proposed medical education and construction programs. This is because the complexes are of greatest importance in graduate education, rather than for undergraduate teaching. It is for the latter that the medical education and construction programs are designed. Moreover, the objective of the complexes is to create an administrative system, with only incidental construction as necessary to implement and

fill out the system's facilities.

5. With regard to the total expense of a complex, what does the Department anticipate would be the relative shares contributed by: The Federal Government? The institutions in the complex? The patients? Others (specify)? Should the shares differ between construction, operating costs, etc? Should the Federal share of operating costs be phased down over a period of years?

Assume a total complex consisting of one medical school with 100 students per class, teaching hospitals containing 1,000 beds, one clinical cancer research institute and 10 cancer stations located in 10 community hospitals each containing 250 beds.

The medical school budget might be $10 million, its real property worth $15 million and its endowment $25 million.

The teaching hospitals might have a budget of $15 million, real property worth $15 million and endowment of $10 million.

The cancer institute might represent $2 million in budget, $5 million in property and $5 million in endowment.

The community hospitals each might average $3 million in budget, $5 million in property, and $2.5 million in endowment.

The total community resources represented in such an (abbreviated) example would be annual expenditures of $37 million, real estate worth $35 million and endowments of $35 million.

Against these totals, the Federal funds might be $8 or $9 million--say less than a sixth of the annual budget. Construction and renovation funds invested over a five-year period might amount to, say, $7 or $8 million--less than a tenth of the real value of the total complex.

Since the construction and renovation costs add to the value of the grantee's property, it seems proper to use matching funds for these purposes. Moreover, the matching formula should be favorable since the purpose is to enhance regional activities not just those of the participating institution.

Since the operating funds are intended to pay the costs of personnel and services in addition to those otherwise available, it seems proper that the additional costs should be paid fully by the grant.

6. In what circumstances, and on what bases, would a patient be expected to pay for services provided by the various elements of the complex?

Patient costs should be paid personally, by third-party agents or from welfare funds, as is normal and customary in this country. To the extent that Social Security insurance funds become available (N.B. 1) they should be used as are any other insurance funds. Only if patients consent to hospitalization for research, teaching or demonstration purposes would hospital costs be paid through the grant.

Organizational

A. Within the complex

1. What are the organizational relationships among the constituents of a medical complex?

This has been covered under Cost & Financing, question 2 above.

2. What is the decision making apparatus regarding:

a. Allocation of the grant funds?

The administration of the applicant institution, with the advice of the local advisory group, would allocate grant funds in accord with the budget of the grant.

b. The practice of medicine including: admission of patients; examining of hospital beds; extension of staff privileges to physicians referring patients; relative responsibilities for patient care distributed among local physicians and dentists, medical complex staff, etc.?

The practice of medicine would be controlled by the professional committees of the participating institutions, as it is now, except that each institution would provide in the application,

and in accordance with regulations, evidence of an acceptable, planned arrangement concerning admission of patients, staff privileges, etc.

3. How will the arrangements necessary to operate a medical complex conform with the bill's stated purpose not to interfere with "the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals?"

This is answered in 2.a. and 2.b. above.

B. Within the State

1. How would the program provided in this bill relate to existing federally supported health programs operated at state and local levels—e.g., Hart-Hills, medical vendor payments under public assistance, maternal and child health, etc.?

This program complements other federally supported programs but does not interfere with them. Funds available through Hart-Hills, Public Assistance, or others would be available to pay patient costs in participating health institutions, as they are now.

This program is designed to bring the abilities, knowledge and skills, presently in individuals in university centers, to bear on a larger number of patients located over a wider geographical area. It should do so by providing improved equipment, services and personnel in stations located in community hospitals. These facilities and people would assist the hospital staff, not compete with them. It should further do so by facilitating transfer of patients into clinical research or university hospital centers where new, expensive and complicated services are available. It should do so by improving the research opportunities in the region. It should do so by greatly improving the continuing education of practicing physicians who form the staffs of local hospitals. And it should do so by furnishing training opportunities now unavailable anywhere for developing specialists in their respective fields.

2. What is the role of state and local officials, who now have health responsibilities, in the planning and operation of complexes?

As stated above, the local advisory group should have representatives from, or should secure the advice of, local or state officials and agencies. The adequacy of such consultation should be determined through the procedures used to review each application.

c. Within the Federal Government

1. What component of the Department will have responsibility for operation of this program? If the NIH, what Bureau(s) and why? If more than one Bureau, what will the division of responsibility be?

The program will be located within the NIH. Final determination as to which Bureau(s) has not been made. It is apparent that the research and training components are closely related to similar programs of the N.I.H. and also that the primary point of contact will probably be the university or its medical school. These are institutions with which the N.I.H. has its maximum experience.

2. How will the complexes meet the needs for highly complicated and expensive diagnostic and treatment services, such as renal dialysis, for patients in Federal hospitals?

Relying as it does upon the university - medical school - teaching hospital aggregation as the center, the complex could command services of any kind for any of its patients to a degree not now possible. It, therefore, in addition to its activities in heart disease, cancer or stroke, an activity devoted to the treatment of burns were located in the medical center, it would be more readily available to a patient whose doctor was a staff member of a local hospital containing a station than to one totally divorced from the complex.

many of the Veterans hospitals now associated with medical schools. These hospitals now have a relationship with the medical center not unlike that of a local hospital which would contain a station. Upon proper determination of need, patients at VA hospitals can be transferred to other institutions for specialized and unavailable procedures. Such transfer, and the concurrent savings in unnecessary duplication, would be greatly facilitated by authorization for the VA to share facilities with other local institutions.

The complexes are totally designed to provide the greatest amount of use for highly expensive equipment and procedures, such as renal dialysis, open-heart surgery, supervoltage irradiation, hyperbaric surgery, low-temperature surgery and other procedures. The degree to which any individual complex is adequate to participate in providing each particular kind of highly advanced care should be determined by experts who are knowledgeable both about the backing of applicable information and the skills of the physicians available in the specific fields.

QUESTION: Why should we give priority attention to Heart, Cancer and Stroke?

ANSWER: 1. These are the killer diseases.--71% of deaths:

Heart Disease	44%
Cancer	16%
Stroke	11%

2. Much that is known in these fields is not being applied today.

3. The bill does provide authority for inclusion, at the option of the applicant, of any other disease found by the Surgeon General to be of major significance to the health of the Nation.

4. The experience gained in establishing these complexes will be invaluable as we explore ways and means of organizing our approach to serious problems of other types.

Q. Does not the emphasis on the categories of heart disease, cancer, and stroke as individual areas of action under the program run counter to the long term effort?

1. To develop the concept of and means for comprehensive care for the whole patient?
2. To avoid fragmentation of medical education and the teaching process?

A. The importance and magnitude of the health problems in the area of heart disease, cancer and stroke demand special emphasis in arrangements to bring these diseases under control and to assure that the advances of research in these areas ~~will~~ are broadly available. Thus these diseases can serve as the initiating point of a program whose eventual culmination will be a general enhancement of health services and the quality of medical care on a broad basis. Thus, although the categorical identification provides an appropriate beginning point, the eventual objective is the kind of comprehensive care which is considered to be the best framework for the delivery of health services. There is little danger that this approach will contribute to any fragmentation of the teaching process.

Question. What major diseases other than heart disease, cancer and stroke does the Department plan to include? On what basis would the Surgeon General and the Medical Complex Advisory Council select other diseasea as proposed in the bill?

Answer. When, in the judgment of experts in a field, it is determined that advances are being made more rapidly than they are being applied (as is the case for heart disease, cancer and stroke) attacks upon these new diseases could well be launched through the organizational structure of medical complexes. In institutions having unique activities relating to other major diseases, the Surgeon General could designate other categories for specific support. To do so, under regulations, evidence that a major national purpose would be served would be required.

QUESTION: What other diseases might be found to be of "major significance to the health of the Nation" so as to be included in the complexes established under this bill.

ANSWER: 1. Following the precedent of heart, cancer, and stroke disease we would envisage assisting the establishment of complexes for diseases involving highly specialized and elaborate treatment (skills, equipment, facilities and procedures).

This might include kidney disease.

2. It might certainly cover disease entities closely related to the skills, equipment, etc. necessary for the treatment of heart disease, cancer, and stroke. For example:

Benign tumors

Lung disease

Cardio-vasmular involvements other than stroke

QUESTION: Could a mental retardation complex be established under this bill?

ANSWER: There is authority in the bill for inclusion, at the option of the applicant, any disease found by the Surgeon General to be of "major significance to the health of the Nation."

There is no doubt that mental retardation is such a disease.

However, under P.L. 88-164 enacted in 1963 there is special authority for the establishment of university affiliated mental retardation facilities and for construction of mental retardation community facilities. Also, states have moneys under P.L. 88-156 1/ for planning comprehensive action to combat mental retardation. The maternal and child health amendments proposed by the Administration this year would authorize $2,750,000 annually for 2 years to states to follow up this planning.

1/ The Maternal and Child Health and Mental Retardation Planning Amendments of 1963.

QUESTION: Could a mental health complex be established under this bill?

ANSWER: There is authority in the bill for inclusion, at the option of the applicant, any disease found by the Surgeon General to be of "major significance to the health of the Nation."

There is no doubt that mental illness is such a disease.

However, under P.L. 88-164, enacted in 1963, there is special authority for construction of community mental health facilities.

And appropriations were made available in 1963 and 1964 for grants to states for planning comprehensive mental health programs.

The Administration is proposing to the Congress this year legislation which would authorize Federal assistance in support of additional staff of comprehensive community mental health centers (S.513-Hill)

Question. What would enactment of this bill accomplish which does not occur at the present time? What are the new elements of organization, treatment, research, or training?

Answer. At the present time, no adequate organizational mechanism exists whereby the highest quality medical care available in university medical centers can be brought to bear widely in a community. Community hospitals are eager for assistance from medical schools, but this usually cannot be provided by existing arrangements. Community-wide planning, whereby expensive duplication of services and equipment is avoided, is rudimentary at best. The provisions of the bill would bring about:

(a) Stimulation of appropriate health planning among medical centers, community hospitals, and other health agencies.

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(d) An improved selection of research patients, who could be selected from the total number in the community rather than from the smaller group now available through a university hospital.

(e) Training more extensive and varied than that now provided, since both a larger number of patients and a more varied set of circumstances would be available to the trainee.

QUESTION: Why is new Federal legislation necessary?

ANSWER: The legislative authorities presently available are directed toward the support separately of essential basic resources for health facilities, manpower, and knowledge. They do not lend themselves to the specific and gigantic task of integrating research, clinical care, and continuing professional education for a coordinated attack on the three "Killer diseases" (heart, cancer, and stroke).

Q. How much of the proposed program of complexes could be carried out under present authorities?

A. The authority provided in S. 596 would allow the creation and support of new mechanisms of relating research, professional education, and high-quality medical care. While all of these activities can be supported to some extent under existing authorities of the Public Health Service, no authority exists to provide for the planning of the complex organizational framework, and the effective linking of research and teaching to diagnosis and treatment of heart disease, cancer, and stroke.

Q. What is the proposed use of the construction authority contained in S. 596 which permits up to 90% matching by the Federal Government?
How would this authority relate to the present proposal for extension and expansion of the Health Research Facilities program and the proposed new authority for nonmatching construction of research facilities for regional and national purposes?

A. The construction authority contained in S. 596 would be used to pay up to 90% of the costs of those additive facilities which are essential to the operation of the complex. We would not anticipate a large amount of new construction under this program, since in most cases the complex would link existing institutions and existing facilities. We would expect a larger number of applications to propose some modification of existing facilities. We would not intend to use the construction authority in S. 596 to provide construction funds which could be supplied under other grant mechanisms of the PHS.

QUESTION: Should a project receive help under this legislation if it could be helped through normal channels--e.g., Hill-Burton program, forhhospital construction?

ANSWER: Our purpose here is to provide for the linkages and mechanisms to assure the overall program through support to staff, services and demonstration programs. Those specific items which require additional funds would be referred to existing mechanisms.

QUESTION: What facilities and equipment could be provided under this legislation that could not be provided under Hill-Burton and Health Research Facilities legislation?

ANSWER: This program is to establish a network--the purpose of program is not construction alone. Construction would be secondary to the central purpose, providing unique, specialized or otherwise unavailable facilities needed for the purpose of this overall program.

QUESTIONS AND ANSWERS CONCERNING REGIONAL COMPLEXES FOR HEART DISEASES, CANCER, AND STROKE AS PROPOSED IN S. 596.

Q. What would be the relationship of the heart disease, cancer, and stroke complexes to the present NIH program for the support of research and research training in the fields of heart disease, cancer, and stroke and other major diseases?

A. The proposed program of medical complexes would not displace present programs of research and research training supported by NIH. The complexes would provide a means for more effectively relating the research and research training activities to clinical training and patient care activities. As the President's Commission on Heart Disease, Cancer, and Stroke made clear, the extensive medical research programs which have resulted from the generous support provided by the Congress to the National Institutes of Health have helped create numerous centers of medical excellence which can be the foundation stones of the proposed complexes.

Question. In what ways would a regional categorical center (for example, a regional cancer center) differ from a clinical research center now sponsored by the National Cancer Institute?

Answer. Although cancer clinical research centers now supported by NCI exhibit a range of characteristics--including many or most of the elements that one would expect to find in a regional cancer center--there are clear differences in concept and purpose.

-- A regional Cancer Center would involve responsibility for improving the quality and availability of cancer research, training, diagnosis, and treatment throughout a specified region. A cancer clinical research center as now supported does not have regional responsibilities and is limited in function to clinical research and research training only.

-- The designation "cancer clinical research centers" refers to a specific limited clinical research component of an existing institution. (Perhaps ten beds with staff and supporting facilities in a cancer research institute, university hospital or similar medical institution.) However, the designation "Regional cancer center" would apply to a broad clinical facility involving an institution as a whole; or a major organizational segment of such an institution.

Question. Would the research and training functions of the complex (including construction of research facilities) be financed through other sources than the grants for establishment and operation of a medical complex?

Answer. Research and research training projects carried out by investigators within the complex could be supported under individual research project grants from appropriate PHS or other granting sources. Similarly, support for a categorical clinical research center approved for incorporation within a complex might be supported directly by a categorical Institute. The pattern in this respect is apt to vary depending upon a variety of institutional funding and cooperative arrangements.

Q. What would be the role of the categorical institutes and the categorical advisory councils?

A. The categorical institutes would continue to provide support for research and research training in their respective fields with the advice of their Advisory Councils. It is anticipated that this support would continue to go to the component institutions of the proposed complexes. Individual investigators within these institutions would still apply for research support through present mechanisms and their proposals would be reviewed for scientific merit and for relevance to missions of the institutes. The proposed program of support for medical complexes would not supplant the categorical institutes as the primary providers of research and research training support in the fields of heart disease, cancer, stroke, and other major diseases.

Q. Would present categorical or general clinical research centers be absorbed into these complexes? If so, would they continue to be financed through the categorical institutes or DRFR?

A. NIH would continue to support general categorical or clinical research centers through present mechanisms. It is likely that many applications for grants under the proposed program of medical complexes would be received from institutions which currently receive NIH support for a general categorical or clinical research center. It would be appropriate for such applications to indicate how present research centers would be related to other parts of the proposed complex. If the present center were included in a complex, support might still be provided through the categorical institute or DRFR; however, the further development of the complex might include financing of the basic core support of the research center through the grant for the complex.

QUESTION: Specifically, what institutions would be eligible for grants? Medical schools? Hospitals? Health departments? Which kinds of grants to what kind of institutions?

ANSWER: A medical school, hospital, health department, research institution or other nonprofit agency would be eligible to apply for a grant to assist them in planning, establishing, or operating complexes.

There would probably be central funding through the applicant, justified on basis of the needs of the complex.

Question: Could a local health department initiate a regional complex project:

Answer: The local health department is eligible. It could also provide the leadership in bringing together the members of the Advisory Council -- i.e. ... health education, hospital administration, medical profession, research scientists, etc.

QUESTION: What organization may apply for diagnostic and treatment station support? The university medical center? Hospital? Health department? Would a proprietary hospital be eligible?

ANSWER: "Diagnostic and treatment station" is defined in the bill to mean a unit of a public or nonprofit hospital or other facility (which could include a medical center, health dept., etc.) A profit-making hospital would therefore not be eligible.

QUESTION: My state doesn't have a medical school, but we have a health department, a good general hospital, and a few nursing homes.

a. How are the folks in my state going to be benefited by this bill?

b. What can we do to become part of a "complex"?

ANSWER: a. Diagnostic and Treatment stations could be in general hospitals. This in turn can be linked to the medical school in an adjoining or nearby state thereby improving the quality of care.

b. The medical profession and the health department could take the initiative in exploring possible relationships with complexes in other states.

Q. 1. What qualitative consideration will be involved in the review and approval of applications for grants for the establishment and operation of regional medical complexes?

2. Will not such centers inevitably mean that these grants will go to the institution and location already capable and well-serviced in respect to research, training, and demonstration capabilities?

3. How will this program help the institutions and areas of the country that do not now have such capabilities?

A. 1. The major qualitative considerations bearing upon the review and approval of applications for grants under this program will be the potential of the proposed program for accomplishing the purposes being sought through the concept of regional medical complexes. Many communities throughout the country have diverse capabilities for improving the quality of services in these critical areas and for establishing relationships between existing research and teaching institutions. What is needed is the plan and the funds to support the cooperative and coordinate relationships which comprise a regional medical complex.

2. While it is probable that the initial awards will involve institutions and programs based upon existing capabilities, a major objective of the program will be to encourage and assist the development of such capabilities on a widely distributed geographical basis.

3. An important part of the concept of the program of the President's Commission is effort directed towards enlarging the number of centers of medical excellence and capability throughout the country. Coordinate use

of other support programs of the Public Health Service such as the General Research Support Grant, the Health Professions Educational Assistance Act and the research and training grant programs will be utilized to advance and geographically equalize capabilities requisite for the development of effective regional medical complexes.

Question. If regional medical complexes must be built around recognized centers of research, training and care competence in the three disease areas, how will the program help to bring quality care to persons living in regions where this competence isn't now found?

Answer. It is probably trud that the first regional complexes will be set up where the largest population concentrations and the required institutional competence coincide geographically. But the program is a national one; and its benefits will not be reserved for heavily urbanized or otherwise favored regions. The Public Health Service, as program administrator, will constantly seek the broadest national access to program benefits. How many regional networks will be required for full national coverage is not clear now; and one can only guess at how long full program implementation will require. (Perhaps ten to twenty years.) But throughout this period--and for most if not for all parts of the country--there should be reasonably steady gains in the quality and accessibility of medical care.

The program will promote these gains in several ways. For example, program implementation requires systematic and continuing assessment of institutional competence (both research and care) in relation to local or regional population needs. The resulting profile of national categorical competence becomes a most useful planning document: categorical strong points become possible components for new or extended regional complexes. Potential strong points logically become the focus of joint local and PHS efforts to raise institutional competence the needed fraction more. Gap areas--if sufficiently serious--can pin point the need for concerted local and national action, possibly including the establishment of new developmental programs.

QUESTION: How is the term "region" used in this legislation?

ANSWER: We envision that such regions might eventually encompass a population of two to 3 million persons, located in a contiguous geographical area, which might be inter- or intra-state or other subdivision.

$10-15 mil annually for 2-3 mil persons
equals $5/capita/yr.

QUESTION: Would you describe the region to be served by such a complex?

ANSWER: The applicant must describe the geographic region and population base. In any case this would have to be a geographic area of sufficient size and population to hold resources necessary and assure their effective utilization. Thus, a region might be part of Greater New York, the entire metropolitan Washington, D. C. area, or a multi-county portion of Kentucky extending from the university medical school.

Question. Will there be a single medical complex for a specific region, with component institutions responsible for categorical specialization? or will there be separate complexes, at least for each of the three major disease categories?

Answer. Each regional medical complex is expected to have (or to develop) component institutions with the necessary competence in the three major disease areas. Separate networks for each disease category would raise administrative costs; might lead to unnecessary duplication of facilities; would increase competition for trained manpower; and tend to unnecessarily fragment provision of quality care for sick persons.

It should be recognized, however, that these regional complexes must build on existing categorical competence; and few regions initially will be equally well served in the three disease areas. Therefore, it is possible that some networks may at first cover just one disease category.

For largest metropolitan areas, with several medical schools and associated hospitals and a number of institutions with required categorical competence, more than one complex may be set up if the need for this is shown.

Question. What are the criteria for evaluating institutions to go into regional complexes?

Answer. There are two over-riding criteria for inclusion of institutions in medical complexes: (1) recognized competence in one or more of the three major disease areas; and (2) willingness to cooperate in a regional framework to make high quality care regionally available. Typically, the regional categorical centers will be drawn from those institutions that are heavily involved in relevant clinical and preclinical research and research training, as well as patient care. Such institutions generally will be found in major university medical centers or associated with them. On the other hand, the prime location for diagnostic and treatment stations is in community hospitals to which the largest number of patients and local physicians have access.

Q. Would the regions to be served by these medical complexes and regional medical centers be determined solely by the inclinations and desires of the applying institutions or would some specification or plan be worked out nationally for this purpose?

A: At the beginning of the program the original definitions would reflect the initial plans and capabilities of these institutions ready to propose the establishment of medical complexes. As this program develops very positive effort would be made to assure equitable geographic distribution of medical complexes. The eventual objective would be the evolution of a national network of medical complexes to assure the availability of the benefits of scientific medicine to all population groups and areas of the nation.

Question. To what extent would these medical complexes be locally controlled and locally run?

Answer. Regional medical complexes would for the most part encompass non-Federal institutions, whose participation in the complex would be supported by grants. Thus, independent responsibility and local initiative would not be diminished by that relationship. Specific arrangements for local control--including the distribution of responsibility among component institutions--will tend to vary among regions. They will also tend to change through time, as one or another administrative problem develops, or more effective forms of cooperation are found. Initial arrangements for local coordination and control must be spelled out in the grant application for the complex. Prerequisites for grant approval probably would include: assurances that a properly constituted local advisory group has been set up and is functioning, that key local agencies, professional groups and institutions have been consulted in setting up the complex, and that cooperating institutions understand and agree to local arrangements.

QUESTION: Will every portion of the United States be covered?

ANSWER: The ultimate objective is to assure that every person have person have access to the best in medical services. This does not mean saturating the country with complexes--for we have neither the manpower nor resources to do so. We view this program as one of developing techniques, stimulating broader coverage in all related services and facilities--with the complexes energizing like demonstrations in a wider community.

Question: How long will it take to develop a national network?

Answer: Decades ()

QUESTION: Where would responsibility for this program's administration lie within the Public Health Service?

ANSWER: In development of our plan for administering this program it is our intent to utilize competencies found in various components of the Public Health Service. Assignment to an organizational unit will be made after the plan has been more fully developed. During the developmental phase the Office of the Surgeon General will assume the responsibility.

QUESTION: Could not provision for continuing education in heart disease, cancer and stroke be made under the educational improvement grants proposed in the Health Professions Educational Assistance Amendments of 1965?

ANSWER: The Health Professions Educational Assistance Act and the proposed amendments are designed to give primary emphasis to the education of students. This proposal would emphasize the continuing education of the practicing professional.

Question. What effect will the proposed categorical approach have on the curricula of medical schools and on undergraduate medical education?

Answer. The complexes will have relatively little effect upon undergraduate medical education. Greater availability of excellent teaching cases, the increased volume of research and the greater rigor of diagnostic and therapeutic methods all will improve medical education, but only secondarily. The great educational impact of the complexes will be on graduate specialty training and upon the continuing education of community physicians.

Question: You are proposing to support staff. What proportion of the staff of a regular teaching hospital or medical school are you going to support under this bill.

a. If they have specialists in cardiology and cancer are you going to pick up their salaries? Aren't you asking us somewhere else to give basic support grants to medical schools? and improved grants too?

Answer: Only those additional professional and technical personnel necessary to operate the components of the "medical complex" would be supported under this bill.

The major emphasis would be on continuation education for for practicing physicians and other professional personnel.

QUESTION: What will be the impact on manpower--now available or being developed? Will this further dissipate our resources?

ANSWER: The complex is a scheme designed to get services to people effectively and efficiently. Thus, although new kinds of medical specialist--teachers will be developed, this will be balanced by personnel economies in improved ways of mobilizing service resources.

The complex arrangement will certainly accelerate the coordination and effective use of existing manpower and improve its quality. Also, the rate of development of manpower will influence rate of development of this program.

Q. The program would seem to greatly increase the requirement for medical and paramedical personnel. How will these needs be met and where is the manpower coming from?

A. This program will indeed increase the demands for medical and other health personnel. This increase, of course, is reflective of the level of health manpower that this Nation requires to provide high quality and truly effective health services. Present shortages of manpower will obviously affect the pace and magnitude of the initial efforts under this program. However, the plan of the President's Commission calls for specific efforts to enlarge health manpower by continued support and increase in level of training programs, initiation of new training programs at both professional and subprofessional levels, and the expansion and support of health educational institutions and programs. Specific effort to support and enlarge the medical and dental educational as a part of this program is encompassed in legislation now before the Congress.

QUESTION: What will be the relation of the complex to area-wide hospital planning under the Hill-Burton program?

ANSWER: The applicant will be required to show the relationship to local planning activities; further, these are anticipated to be given consideration through the mechanisms of the applicants advisory committee.

Question: Is the programa, then, another aspect of regional or community planning for health? How would it differ from areawide hospital planning, planning community mental health centers, for example which are presently authorized?

Answer: Emphasis on continuing education--rapidly employing specific knowledge in treatment.

Not any one of these per se links research, training, and patient care, Bill does require relationship with any existing planning activities.

QUESTION: Aren't you really talking about developing community plans for service here? Isn't that the big void to fill? We seem to be doing a lot of this constructing, research, and training with other support.

ANSWER: Community planning for service can subsequently be related. This program is concerned with the quality of health service in communities--by bringing to bear the advances within teaching and research centers to the community services, through the community hospital and the practicing professional.

Question: Aren't you really talking about planning money and effort here? Don't you have enough Federal aid for all these things if you could only join them together by planning?

Answer: No, we don't have all the pieces--we are aware of gaps, of varying degrees, in many areas. This program provides for planning plus the organizational linkages and elements of the networks that are inter-institutional, etc., and that link the professional practitioners to the research and the educational system.

QUESTION: How is a 90% Federal share justified in this program as contrasted to other PHS grant programs?

ANSWER: The higher Federal share is justified by the urgency of the need to launch a concerted attack on these 3 "Killer diseases," and the necessity of rapid development of systems for provision of high quality patient care so that research knowledge can be applied as rapidly as possible to people.

Question: What share of the funds would be used for construction?

Answer: A minor portion even in the earliest phase of the program.

Minimal if any -- once the complex has become established.

Question. What will the grant monies be used for, e.g., Professional staff, ancillary staff, equipment, renovation, new construction, patient care? In what proportion? Who will decide?

Answer. Grant funds will be used for professional staff, ancillary staff, equipment, renovation, construction and patient care, but the latter only for care allocable to training, research or demonstration. The proportions would be as set forth in proposed budgets by the applicant institutions. Such budgets would be reviewed, both by medical scientists and by administrative specialists, and would be subject to regulations similar to those promulgated for the clinical research units now operated through the NIH.

QUESTION: How do you contemplate using $50 million in this first year?

ANSWER: We envision the establishment of four such complexes in the first year of operation, ranging in cost from $10-15 million each. Roughly, we believe this may be distributed as follows:

12.5 million per complex, generally as follows:

$2.5 million - for the administrative network and communication lines of the medical center.

$5.0 million - for basic support of specific activities in heart disease, cancer and stroke.

$5.0 million - to establish 20 diagnostic and treatment stations in local and community health facilities. ($250,000 per station)

$12.5 million

QUESTION: How would the complexes help the practicing physician who is not otherwise associated with a medical school, teaching hospital, or other sponsoring institution?

ANSWER: Three ways are envisioned: (1) he has access, through his local affiliations, to the programs of continuing education carried out by the complex, and (2) he had recourse to consultation and assistance, (3) he may refer his patient to the center.

Q. The bill provides for the payment by the patient or a responsible third party, for the services rendered under this program except when such services are incident to research teaching or demonstration.

1. Who will be the recipient of and what will be the disposition of such collected fees?
2. Should they not be used to offset, reduce or otherwise reimburse the Federal expenditure? What arrangements will be made for this?

A. Fees received by institutions comprising a medical complex for services rendered under this program will be received by the normal collection framework of such institutions and will be used to reduce or reimburse for the Federal expenditures made in support of the program of the medical complex. Accounting arrangements will be worked out which will provide for appropriate allocation of costs under this program between the Federally supported activities and those constituting the normal operating costs of the participating institutions and these patterns will be used to allocate income received for services rendered to provide for proper reimbursement for Federal expenditures.

Question: Will the costs of transporting patients to regional centers be paid for under this program?

Answer: In specific situation where essential to the purposes of the program, Yes -- i.e. for research, training, or demonstration purposes.

Question: How would a "demonstration" patient be differentiated from one who was an ordinary patient?

Answer: A "demonstration" patient is a variation on a teaching patient, also a variation of a research subject. Who would be hospitalized under agreements clearly identifying his status. Block grant to medical complex. Regular patient care costs are to ~~lie~~ be borne by other mechanisms -- voluntary insurance, etc.

Question: You say you are not going to pay patient care costs except those incident to training, research, or demonstration activities. How do you judge whether a patient is being used for training purposes?

Answer: If hospitilized only for teaching purposes -- yes.

Extra costs above normal, if hospital stay were extended for a few days to facilitate teaching.

Question: You have stated patient care will be provided only for demonstration, training, or research. Won't this mean flooding elements of the complex with persons seeking quality service?

Answer: Part of the applicant's submitted program will include procedures to be established to meet this problem.. Much as at our National Clinical Center, eligibility will be time-phased for either research, training or demonstrations. It will not be a continuing or constant operation. Each complex will determine its own referral system. The key to this referral system is the practicing physician.

QUESTION: Are you going to serve more patients (if so--how? and how many?) or just raise the quality of care of patients now being served?

ANSWER: Both. This program will be providing something that is not attainable now except in some areas. The patients who have these diseases will have access to better and more intensive care. More service will be available to them with their physicians having available to them better resources and consultation.